TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF SUPPLEMENTAL FOOD PROGRAMS
INFORMED CONSENT/SIGNATURE SHEET

Patient ID/Record No.

Name-Last | First | Middle | Proof of Identity

Date	Program	No. in Household	Family Income	Time Period	Patient Signature WIC/CSFP Statements Read on Back	Health Department Employee Signature/Title

INFORMED CONSENT FOR SUPPLEMENTAL FOOD PROGRAMS
WIC/CSFP

REQUIRED TO BE READ

1. I understand that the Supplemental Food Programs (Women, Infants, and Children "WIC" and Commodity Supplemental Foods "CSFP") are to provide nutritious food and to collect medical data. It is by my own free will that I participate in this program. As a parent or guardian, I hereby authorize the Public Health Nurse and/or other health professionals to perform medical screening procedures on me or my child named above, including height, weight, hematocrit, physical, medical history and evaluation procedures, and I authorize the use of the medical data collected.

2. I understand that this certification is being submitted in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that committing acts of program abuse, intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under Tennessee and Federal statutes.

3. **I understand that I may not receive WIC vouchers and food from the Commodity Supplemental Food Warehouse during the same period of time. I realize to do so would be dual participation and an act of program abuse. As parent or guardian I certify that the person being certified for WIC is not currently participating in CSFP, or another WIC Program. The person being certified for CSFP is not currently participating in WIC or another CSFP.**

   I realize that if found receiving foods from WIC and CSFP at the same time, my benefits can be stopped immediately. I may still receive such assistance as food stamps and quarterly distributions of commodities from other agencies (excluding WIC and CSFP) for which I am eligible.

4. I authorize the Supplemental Food Program to release this information to Federal and State Agencies who administer assistance programs, for the purpose of determining my and/or my child's eligibility for their services.

5. I understand that standards for participation are the same for everyone regardless of race, color, national origin, age, sex, handicap, religious or political belief.

6. I may request a fair hearing on any decision made regarding eligibility for the Program.

7. I have been advised of my rights and responsibilities under WIC/CSFP. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge. I understand that my signature on the reverse side of this form indicates that I have read and understand, or have had the above information read and explained to me.